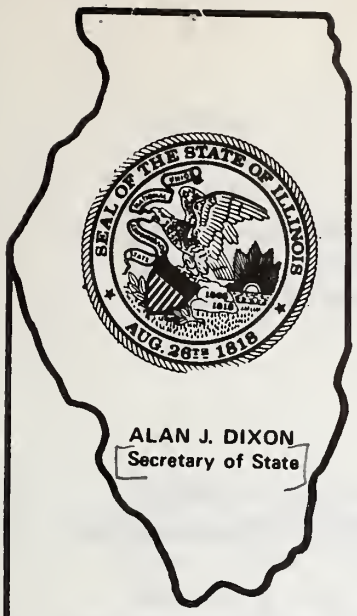

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EDITOR SPECIAL NOTICE

TO ALL AGENCIES

AS OF JANUARY 1, 1978 ALL AGENCIES ARE UNDER THE ILLINOIS ADMINISTRATIVE PROCEDURE ACT.

A. Per the Administrative Procedure Act - Section 7.01, any rule on file with the Secretary of State, on January 1, 1978 shall be *void* 60 days after that date unless within such 60 day period the issuing agency certifies to the Secretary of State that the rule is currently in effect.

B. SECRETARY OF STATE - *Rules on Rules*

Article III - Rule 3.03

No *Proposed Rules* will be accepted by the Secretary of State, Rules and Regulations unless the proper format is followed - TAKE SPECIAL NOTE:

1. If the proposal is a new rule, the full text of the new rule; or

2. If the proposal is an amendment to a rule, the full text of the existing rule with proposed changes indicated. Language being deleted shall be indicated by lining through the text and new language shall be indicated by underlining; or

3. If the proposal is a repealer, the full text of the rule to be repealed.

If any questions should arise, please feel free to contact:

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DEPARTMENT OF REGISTRATION AND EDUCATION

NOTICE of proposed amendment to ILLINOIS MEDICAL PRACTICE ACT - Adoption of Rules relating to mandatory CONTINUING MEDICAL EDUCATION for those licensed to practice medicine under the Illinois Medical Practice Act.

NOTICE

PLEASE TAKE NOTICE THAT the Department of Registration and Education pursuant to Section 5.1 of the Illinois Medical Practice Act (Ill. Rev. Stat. 1975, Ch. 91, Sec. 5.1, eff. July 1, 1976) proposes to adopt rules relating to mandatory continuing medical education requirements for renewal of licenses to practice medicine in all of its branches or to treat human ailments without the use of drugs or medicines and without operative surgery.

DESCRIPTION OF THE SUBJECT MATTER INCLUDED

These rules (which, if adopted, will be designated Rule XI-Continuing Medical Education (CME)) are organized as follows:

Art. I. Biennial Renewal of License

Art. II. Categories of CME for which Credit shall be awarded (this article includes requirements for approval by the Department of institutions and orgainzations of all kinds which offer CME credits.)

Art. III. Certification of Compliance with CME requirements.

Art. IV. Waiver of CME requirements and extension of time within which to comply.

Art. V. Noncompliance with Rule XI.

Art. VI. Confidential information.

RULE XI

CONTINUING MEDICAL EDUCATION

Forward:

This RULE is promulgated pursuant to Section 5.1 of the Medical Practice Act, approved June 20, 1923, as amended ("the Act"), and in conformity with the requirements of that Section with respect to mandatory continuing medical education (hereinafter called "CME") for persons licensed in Illinois pursuant to the Act.

ARTICLE I. BIENNIAL RENEWAL OF LICENSE

Section 1. The commencement date of the next renewal period for which licenses to practice medicine in all of its branches or to treat human ailments without the use of drugs or medicines and without operative surgery is July 1, 1978. At the time a person applies to the Department of Registration and Education of the State of Illinois ("Department") for renewal of the license to him or her pursuant to the Act for the renewal period commencing July 1, 1978 ("first renewal period"), or for any renewal period after June 30, 1980, such person ("renewal applicant" or "applicant") shall, subject as hereinafter provided, submit to the Department evidence, on forms supplied by the Department, of his or her CME:

(a) During the period commencing January 1, 1978, and ending March 31, 1978, in the case of applications for renewal for the first renewal period and thereafter

(b) During any period of 24 calendar months immediately prior to April 1 in the year in which will occur the commencement date of the period for which renewal of such license is sought. (The period of 24 calendar months immediately prior to the April 1 in which will occur the commencement date of the renewal period for which renewal of such license is sought is hereinafter sometimes called "prerenewal period.")

Section 2. The Department shall require 100 credit hours of CME relevant to the practice of medicine in all of its branches or the practice of any system or method of treating human ailments without the use of drugs or medicines and without operative surgery, as the case may be, for which such applicant holds a license issued by the Department, such credit hours to be distributed, except as hereinafter in this Section 2 stated, over a period of two years, and in any category or categories hereinafter designated, all as such applicant may elect, during the applicable prerenewal period; provided that, anything herein to the contrary notwithstanding, for the prerenewal period ending March 31, 1978:

(a) Each applicant shall be required to have a total of 12 credit hours (equivalent to an average of 4 credit hours of CME for each full calendar month during the period commencing January 1, 1978, and ending March 31, 1978), and the same may be distributed as the applicant may elect, subject as provided in the immediately succeeding subdivision (b) and

(b) Each applicant shall be required to have, and include, as part of the CME required hereunder, during the period commencing January 1, 1978, and ending March 31, 1978, both dates inclusive, at least one-third of the required CME credit hours (i) in the Category described in Section 1 of ARTICLE II as CATEGORY 1 or (ii) in the Category described in Section 3 of ARTICLE II as CATEGORY 1. The total number of required hours of CME, or any part thereof, may have been earned at anytime during the period of 24 months prior to April 1, 1978.

ARTICLE II. CATEGORIES OF CME FOR WHICH CREDIT SHALL BE AWARDED

Section 1. Activities approved by the Department for which CME credit may be earned by each person licensed to practice medicine in all of its branches during each prerenewal period are as follows:

CATEGORY 1. A minimum of 50 hours - up to the full 100 hours - in formal learning programs as defined in (a) below or by either or both teaching and medical care evaluation activities as defined in (b) below or in compliance with requirements equivalent to those provided by the applicable Illinois statutes or rules or regulations with respect to requirements of the kind hereinafter set forth in Section 2 of this Article II:

(a) At least 20 hours of verified attendance at any formal education program which is sponsored or cosponsored by an organization accredited for CME by American Medical Association ("AMA") prior to July 1, 1977, or accredited on or after July 1, 1977, by the Liaison Committee on Continuing Medical Education ("LCCME") or by the Committee on Continuing Medical Education of the American Osteopathic Association or by any other agency or institution recognized or accepted by the Department for the provision of continuing medical education, all subject to such further determination or determinations as may be made by the Department at any time or from time to time.

(b) Up to 30 hours of all or any verified teaching of medical students, postgraduate medical trainees, or of verified teaching of preceptees or practicing physicians in CME programs sponsored or cosponsored

by any organization, agency or institution referred to in the immediately foregoing subparagraph (a) of this Category 1 or of verified participation in the activities of a medical audit, patient-care evaluation, utilization review committee or similar committee of a hospital licensed by the Illinois Department of Public Health; or verified participation in patient-care review activities of a Professional Standards Review Organization or other regional agency authorized by State or Federal law to monitor the quality of medical care; or verified participation in patient-care review activities of a medical foundation or other physician-organized or sponsored agency established voluntarily to monitor the quality of medical care, which such foundation or such other organization is approved by the Department.

CATEGORY 2 Up to 50 hours of:

(a) Verified attendance at, or participation in, meetings or recognized specialty or professional organizations, teaching rounds and exercises in postgraduate programs heretofore approved by the Liaison Committee on Graduate Medical Education ("LCGME"), or by the Committee on Continuing Medical Education of the American Osteopathic Association;

(b) Verified attendance at lectures, grand rounds, departmental or hospital scientific meetings, and similar activities in LCCME accredited hospitals which are not organized as formal education programs of the kind referred to in CATEGORY 1 of this Section 1 of ARTICLE II;

(c) Verified formal learning experiences sponsored by recognized agencies not accredited for CME, but approved by the Department, in subjects not directly related to clinical medicine that facilitate physician performance, such as courses in computerized patient-record systems, or training - including advanced degree programs - in education, health administration, and similar subjects;

(d) Papers prepared and delivered before recognized specialty societies, papers published in nationally recognized medical journals, or a chapter in a medical book, or an exhibit prepared for a medical meeting, each appropriately verified; and

(e) Up to 50 hours - in verified self-instruction - individual use of audio-visual materials, use of teaching devices, and study of medical literature - which is sponsored or cosponsored by any recognized medical college, institution or national, state or local medical association, or national specialty society, or organization similar to any of the foregoing.

(f) Any excess credit hours from CATEGORY 1, paragraph (b), can be used to satisfy CATEGORY 2 requirements.

Section 2. Additional activities approved by the Department for which CME credit may be earned by any person licensed to practice medicine in all of its branches during each prerenewal period are as follows:

Up to the full 100 hours - in, or toward, verified compliance with any of the following requirements, provided that the applicable specific requirements, in each case, are substantially equivalent to, or greater than, those imposed by the applicable Illinois statutes or by these or any other applicable governmental rules or regulations:

(a) CME requirements of another state medical licensing authority;

(b) Certification or Recertification by a specialty board;

(c) CME requirements of a national specialty society; or

(d) Six months or longer, working full time in a residency program approved by the LCGME or in a postresidency fellowship,

all subject to the approval of the Department.

Section 3. Applicants who are licensed to practice a system or method of treating human ailments without the use of drugs or medicines and without operative surgery may earn CME credit during each prerenewal period for activities hereinafter set forth in this Section and then only to the extent stated:

CATEGORY 1 (a) A minimum of 50 hours - up to the full 100 hours - in verified attendance at any formal education program which is sponsored, cosponsored or accredited by:

(i) any chiropractic institution having approved status with the Council on Chiropractic Education approved by the Department or any chiropractic school or other chiropractic institution approved by the Department; or

(ii) American Chiropractic Association or International Chiropractic Association, or any of their respective Council and Diplomate programs; or

(iii) Illinois Chiropractic Society or Prairie State Chiropractic Association, or any of their respective local chapters;

all subject to such further determination or determinations as may be made by the Department at any time or from time to time.

(b) Up to 30 hours of all or any verified teaching of chiropractic students, or postgraduate chiropractic trainees, or of verified teaching of preceptees or practicing chiropractors in CME programs sponsored or cosponsored by any organization referred to in the immediately foregoing subparagraph (a) of this Category 1.

(c) Up to the full 100 hours - in, or toward, verified compliance with any of the following requirements, during each prerenewal period, provided that the applicable specific requirements, in each case, are substantially equivalent to, or greater than, those imposed by the applicable Illinois statutes or by these or any other governmental rules or regulations:

(i) CME requirements of another licensing authority with respect to chiropractors;

(ii) Certification or Recertification by a specialty board;

(iii) CME requirements of national chiropractic specialty society; or

(iv) six months or longer, working full time in a residency program approved by the Council on Chiropractic Education, or in a post-residency fellowship; or,

(v) attendance at programs of the kind referred to in subparagraph (a) of CATEGORY 2 of Section 1 of ARTICLE II.

CATEGORY 2 Up to 50 hours of any or all of the following:

(a) Verified self-instruction - individual use of audio-visual materials, use of teaching devices, and study of chiropractic or medical literature - which is sponsored or cosponsored by any institution or other organization hereinbefore referred to in subparagraph (a) of CATEGORY 1 of this Section 3 of ARTICLE II; and

(b) Papers prepared and delivered before recognized specialty societies, papers published in nationally recognized medical or chiropractic journals or a chapter in a chiropractic book or any exhibit prepared for a chiropractic meeting, each appropriately verified.

Section 4. Where any of the activities hereinbefore described is required by the terms hereof to be verified, the applicant may satisfy such requirement by the performance thereof and the filing with the Department of a statement under oath describing the particular activity or activities for which CME credit is at any time claimed with such particularity as shall be satisfactory to the Department, subject to the right of the Department to require further details with respect thereto in such form as the Department shall specify.

Section 5. One clock hour substantively spent satisfying the requirements of CATEGORY 1 or 2, or any part thereof, of Section 1 of ARTICLE II, or of Section 2, or any part thereof, of ARTICLE II or of CATEGORY 1 or 2, or any part thereof, of Section 3 of ARTICLE II shall equal one credit hour for the purpose of satisfying the CME credit-hour requirements hereof during any prerenewal period.

Section 6. Hospitals, organizations, associations, councils, committees, societies, colleges, schools, institutions or other entities (hereinafter called, individually, "sponsor") as a condition to being approved, or continuing to be approved, or having activities accepted by the Department, for CME credits which may be earned by renewal applicants in order to comply with CME requirements herein stated, shall at all times:

(a) Maintain accurate records of the names and addresses of all renewal applicants attending or participating;

(b) Record accurately in such records the exact number of hours of such attendance or participation, or both, by each renewal applicant;

(c) Issue to each renewal applicant a certificate certifying the exact number of hours of attendance or participation or both, signed by the registrar or other authorized officer of such sponsor; and specify that such certification is subject to the terms of this Section 6 of this ARTICLE II;

(d) Make available to any renewal applicant who, in any way, has attended, engaged or otherwise participated in any CME activities under the auspices of such sponsor and paid in full all tuition or other fees therefor, or to anyone designated by such applicant, the records or pertinent part thereof, requested by such applicant, for examination and audit during the regular office hours of such sponsor; and

(e) Maintain records in compliance with all applicable accreditation requirements.

Upon the failure of any sponsor to comply with any of the foregoing requirements, the Department, after notice to such sponsor and hearing before, and recommendation by, the Medical Examining Committee, may refuse to accept any such attendance or participation in any CME activities, courses or programs sponsored or cosponsored as in compliance with CME requirements under this RULE XI and may, by reason of such failure, thereafter refuse to accept, for CME credits, attendance or participation in, any such sponsor's CME activities, courses or programs until such time as the Department receives reasonably satisfactory assurances of compliance with this Section and all other applicable provisions of this RULE XI.

ARTICLE III. CERTIFICATION OF COMPLIANCE WITH CME REQUIREMENTS

Section 1. Each application for biennial license renewal shall be under oath. Each renewal applicant shall, except as provided in Section 3 of this ARTICLE III and in ARTICLE IV of this RULE, certify, on such license renewal application, to such applicant's full compliance with the CME credit-hour requirements set forth in ARTICLE I of this RULE during the pertinent prerenewal period by marking an "X" or check mark in a box provided for such purpose or by so certifying in any other way which shall be satisfactory to the Department.

The Department may, but shall not be required:

(a) To set forth on such application the question:

Has the applicant fully complied with the valid applicable CME requirements for the renewal of such applicant's license which this application seeks? and

(b) To provide such applicant with the opportunity to make an affirmative answer on such application in any of the ways hereinbefore provided in this Section.

Section 2. The Department relies upon each individual applicant's integrity in certifying to such applicant's compliance with the CME requirements herein provided. Nevertheless, the Department reserves the right to require, if it so elects, any renewal applicant to submit, in addition to such renewal application, further evidence satisfactory to the Department demonstrating compliance with the CME requirements herein

provided. Accordingly, it is the responsibility of each renewal applicant to retain or otherwise be able to have, or cause to be made, available, at all times, reasonably satisfactory evidence of such compliance.

Section 3. Any applicant who is first licensed in Illinois by examination after the effective date of this RULE, shall not be required to comply with any CME requirements herein set forth for the first renewal of such applicant's license.

Section 4. In the event that the Department shall find, with respect to any application for license renewal and any other evidence of compliance with the CME requirements of this RULE submitted to it by any renewal applicant that:

(a) Such application or any further evidence of compliance with the CME requirements herein provided for are, for any reason, unsatisfactory to the Department, whether because the Department has questions or doubts with respect to any matters set forth in such application or such further evidence, or both, or for any other reason whatsoever, or

(b) The Department has no satisfactory evidence demonstrating that such applicant has complied with the CME requirements provided by this RULE after requesting such applicant to furnish or otherwise provide such evidence,

the Department shall give to such renewal applicant personally or by written notice, by registered or certified mail, return receipt requested, addressed to such applicant at the address to which such applicant's last renewal application was addressed or any subsequent address furnished by such applicant, of (i) such finding, (ii) its proposed recommendation to the Director on the basis of such finding, and (iii) the date and place of hearing before the Medical Examining Committee. At such hearing such applicant shall have an opportunity to be heard with respect to such finding and proposed recommendation and to present evidence satisfactorily showing full compliance with the applicable CME requirements of this RULE or reason for waiver of such requirements, or any of them. Such applicant or the Department may have, if either party so elects, a stenographer present at such hearing to take down any testimony given thereat and preserve a record thereof, all at the expense of such applicant. After considering, also, such further evidence relating to the matters set forth therein as shall have been filed with the Department by such renewal applicant or, after reasonable notice to the applicant, by anyone else or presented at such hearing, the Medical Examining Committee shall present to the Director a written report of its findings and recommendations as to whether such applicant has satisfied, during the prerenewal period involved, the requirements of this RULE with respect to the relevant CME requirements, or reasons for waiver of such requirements, or any of them, and, accordingly, whether such applicant's application for renewal of license should be granted. A copy of such report shall be served upon such renewal appli-

cant either personally or by registered or certified mail addressed as aforesaid. Within 20 days after such service, such renewal applicant may present to the Department his or her written motion for a rehearing, if desired, and shall specify the particular grounds therefor.

ARTICLE IV. WAIVER OF CME REQUIREMENTS AND EXTENSION OF TIME WITHIN WHICH TO COMPLY

Any renewal applicant seeking renewal of license without full compliance with these CME requirements with respect to having the required number of credit hours of CME shall file with the Department application for license renewal, the required fee therefor, an affidavit setting forth the facts concerning such noncompliance, and a request for waiver of the CME requirements on the basis of such facts. Thereupon, if from such affidavit or any other evidence submitted, each case being considered by the Medical Examining Committee, on an individual basis, and upon written report and recommendation of the Committee, the Department finds:

(a) That, during the applicable prerenewal period, there was an absence of opportunities for CME in the locality or localities in which such renewal applicant was engaged in the lawful practice of the licensed profession during such prerenewal period and that the absence of such opportunities would interfere with the adequacy of medical services in such locality or localities or

(b) That good cause, as hereinafter defined, has been shown for granting to such renewal applicant an extension of time within which such applicant shall complete compliance with all such CME requirements or any part thereof with which such applicant has not complied,

the Department:

(i) In the case of situations involving item (a), shall waive the enforcement of such CME requirements and renew such license for the renewal period for which such applicant has applied and

(ii) In the case of situations involving item (b), shall specify the length of the extension of time granted, if any, within which such renewal applicant shall complete compliance with all such CME requirements and during which period of extension such renewal applicant may continue to practice, subject as hereinafter provided, and shall notify such applicant thereof.

Good cause shall be, but is not limited to, any of the following:

(a) serving full time in the regular armed forces of the United States of America during any part of the applicable prerenewal period.

(b) inability to devote sufficient hours during the applicable pre-renewal period to CME because of illness, incapacity, undue hardship or any other extenuating circumstances.

Any waiver of, enforcement of, or extension of time granted for, compliance with such CME requirements shall be without prejudice to the Department's power or right to refuse license renewal at any time or from time to time for any renewal period for which application is filed or for any remaining balance of such period because of noncompliance with CME requirements during any prerenewal period or any other proper ground for such refusal.

Hearing before the Medical Examining Committee with respect to any request for such waiver may be granted only if such hearing is requested at the time the request for such waiver is filed with the Department. The renewal applicant requesting such waiver shall be given at least 20 days written notice of the date, time and place of such hearing by certified mail, return receipt requested.

ARTICLE V. NONCOMPLIANCE WITH THIS RULE XI

In the event that any renewal applicant becomes ineligible for license renewal because of failure to comply with any of the provisions of this RULE XI such applicant's license shall not be renewed pursuant to the renewal application theretofore filed by such applicant or pursuant to any other renewal application at any later time filed by such applicant and shall expire, subject to reinstatement as hereinafter in this ARTICLE V provided. The Medical Examining Committee may recommend to the Director the reinstatement of any such applicant whose license has expired upon receipt of satisfactory evidence that such applicant or licensee has corrected any deficiency in the required credit hours of CME and is then in all other respects in compliance with this RULE and the Act.

ARTICLE VI. CONFIDENTIAL INFORMATION

Information which in any way relates to the CME of any licensee under the Act or the participation of such licensee therein, as same pertains to any aspect of such licensee's practice liability, public image or relationships with individual patients, shall be deemed strictly confidential, except that such information which may, at any time, be in the Department's files or other records may be made available:

(a) Upon written consent of such licensee or, in case of such licensee's death or disability, of such licensee's personal representative; or

(b) At any hearing in which the Department or its Director or any other personnel of the Department, or the Medical Examining Committee, or the Medical Disciplinary Board shall be involved or otherwise interested; or

(c) At any court or administrative proceeding or at the taking of testimony, whether orally or by deposition, or both, in connection with any such proceeding, in which the Department or its Director or any other of its personnel shall be served with a subpoena or a subpoena duces tecum, as the case may be, of a court or administrative body of competent jurisdiction upon payment of the same fees and mileage as prescribed by law in the case of judicial proceedings in civil cases in Illinois courts.

TIME AND MANNER IN WHICH INTERESTED
PERSONS MAY PRESENT THEIR VIEWS
CONCERNING THE PROPOSED ACTION

Notice is hereby given that all interested persons may submit, in writing, data, views, arguments or comments on the proposed rules. All submissions will be fully considered. Submissions must be received by February 6, 1978 and should be sent to:

Medical Examining Committee
Department of Registration and Education
55 East Jackson Boulevard, 17th Floor
Chicago, IL 60604

ILLINOIS DEPARTMENT OF PUBLIC HEALTH

PROPOSED RULES AND REGULATIONS

FOR LICENSURE OF HOME HEALTH AGENCIES

The Illinois Department of Public Health proposes to adopt Rules and Regulations for licensure of Home Health Agencies in accordance with the Home Health Agency Licensing Act (Chapter 111½, Section 2801, et. seq., 1977).

These proposed regulations contain pertinent definitions applicable to the Act. Section 3.0 describes the Administrative and Organizational structure of the Agency. Section 4.0 describes the staffing pattern and related responsibilities Section 5.0 describes the health services to be provided by the Agency. Section 6.0 describes the protocol for licensure.

If any interested persons wish to submit views, arguments or comments concerning these proposed regulations, they may do so by submitting a request for opportunity to comment within 14 days, beginning on the date of publication. This request should be directed to: Leonard A. Kutilek, Chief, Division of Ambulatory Care Review, Office of Health Facilities and Quality of Care, Illinois Department of Public Health, 525 West Jefferson Street, Springfield, IL 62761. The Department will consider all written comments received within 45 days from date of publication.

The text of the rules and regulations follows:

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1.0 PURPOSE

The following rules and regulations are set forth in accordance with Section 6 of the Home Health Agency Licensing Act (Chapter 111½, Section 2801 et seq., 1977).

2.0 DEFINITIONS

Agency - refers to Home Health Agency unless otherwise designated.

Administrator - shall be anyone of the following: 1) a physician, 2) a registered nurse licensed in Illinois (with two years experience in nursing, preferably in public health nursing), 3) an individual with a bachelor's degree, which includes at least 24 semester hours of college level health services administration courses and at least one year of administrative experience in the health care field.

Branch Office - a location or site from which a home health agency provides services within a portion of the total geographic area served by the parent agency. The branch office is part of the home health agency and is located sufficiently close to share administration, supervision and services in a manner that renders in unnecessary for the branch independently to meet the conditions of participation as a home health agency.

Bylaws or Equivalent - a set of rules adopted by a home health agency for governing the agency's operation.

Clinical Note - a dated written notation by a member of the health team of a contact with a patient containing a description of signs and symptoms, treatment and/or drug given, the patient's reaction and any changes in physical or emotional condition.

Clinical Record - an accurate account of services provided for each patient and maintained by the agency in accordance with accepted professional standards.

Department - The Department of Public Health, State of Illinois.

Dietitian - a person who is eligible for registration by the American Dietetic Association.

Director - the Director of the Department of Public Health, State of Illinois.

Discharge Summary - the written report of services rendered, goals achieved and final disposition at the time of discharge from service.

Geographic Service Area - the area from which patients are drawn. This area is to be clearly defined by readily recognizable boundaries.

Health Systems Agency - an area-wide health planning organization or comprehensive health planning organization as defined by the Illinois Health Facilities Planning Act, and as authorized by P.L. 93-641.

Home Health Agency - a public agency or private organization which provides skilled nursing services and at least one other home health service as defined in these regulations.

2.0 DEFINITIONS (CONTINUED)

Home Health Aide - a person who shall have training in those supportive services which are required to provide and maintain bodily and emotional comfort and to assist the patient toward independent living in a safe environment. If the aide receives training through a vocational school, licensed/certified home health agency or hospital, the curriculum shall be documented. If training is received through the agency the curriculum shall consist of at least 42 hours which include six hours of introduction to the home health services program, role of the aide and differences in families; six hours of instruction relating to nutrition, food and household management; 24 hours of instruction relating to personal care activities and six hours of instruction relating to ethics and conduct, personal hygiene, agency policies and reports and records. Personal care activities shall be taught by a registered nurse. When prior training is not equivalent to the minimum herein described, the necessary supplementary training must be provided and documented.

Home Health Services - services provided to a person at his residence according to a plan of treatment for illness or infirmity prescribed by a physician. Such services include part time and intermittent nursing services and other therapeutic services such as physical therapy, occupational therapy, speech therapy, medical social services or services provided by a home health aide.

Homemaker - a nonprofessional person who provides home management services for a person and/or family.

Nutritionist - a person who has a baccalaureate degree with major studies in foods, nutrition and dietetics; has had a minimum of two years of experience in the dietetic service of a health care institution and participates annually in continuing dietetic education.

Occupational Therapist - a person who is a graduate of an occupational therapy curriculum accredited jointly by the Council on Medical Education of the American Medical Association and the American Occupational Therapy Association or is eligible for the National Registration Examination of the American Occupational Therapy Association; or, has two years of appropriate experience as an occupational therapist and has achieved a satisfactory grade on a proficiency examination conducted, approved or sponsored by the US Public Health Service, except that such examinations of proficiency do not apply with respect to persons initially licensed by a state or seeking initial qualification as an occupational therapist after December 31, 1977.

Occupational Therapy Assistant - a person who meets the requirements for certification as an occupational therapy assistant established by the American Occupational Therapy Association; or, has two years of appropriate experience as an occupational therapy assistant and has achieved a satisfactory grade on a proficiency examination conducted, approved or sponsored by the US Public Health Service, except that such determinations of proficiency do not apply with respect to persons initially licensed by a state or seeking initial qualification as an occupational therapy assistant after December 31, 1977.

2.0 DEFINITIONS (CONTINUED)

Part Time or Intermittent Care - services which are provided for less than eight hours a day and less than 40 hours per week.

Patient - a person who is under treatment or care for illness, disease or injury.

Patient Care Plan - a coordinated and combined care plan prepared by and in collaboration with each discipline providing service to the patient and/or family.

Person - any individual, firm, partnership, corporation, company, association or any other legal entity.

Physical Therapist - a person who is licensed as a physical therapist by the State of Illinois and who meets the Federal Conditions of Participation for Home Health Agencies (USC 42 Section 1395x Health Insurance for the Aged Act).

Physical Therapist Assistant - a person who 1) has graduated from a two year college level program approved by the American Physical Therapy Association or 2) has two years of appropriate experience as a physical therapist assistant and has achieved a satisfactory grade on a proficiency examination conducted, approved or sponsored by the US Public Health Service, except that such determinations of proficiency do not apply with respect to persons initially licensed by a state or seeking initial qualification as a physical therapist assistant after December 31, 1977.

Physician - any person licensed to practice medicine in all of its branches under the "Medical Practice Act" of the State of Illinois.

Plan of Treatment - a plan based on the patient's diagnosis and the assessment of the patient's immediate and long range needs and resources. The plan of treatment is established in consultation with the home health services team which includes the attending physician, pertinent members of the agency staff, the patient and members of the family.

Practical Nurse (Licensed) - any person currently licensed in the State of Illinois, performing selected acts, including the administration of treatment and medications, in the care of the ill, injured or infirm, the maintenance of health and prevention of illness of others, under the direction of a registered nurse.

Professional Advisory Group - a group composed of at least one practicing physician, one registered nurse (preferably a public health nurse) and two representatives from other health professions. No more than 75% of the group's members shall be owners or employees of the home health agency or an organization of which it is a subdivision.

2.0 DEFINITIONS (CONTINUED)

Progress Notes - a dated, written notation by a member of the health team summarizing facts about care and the patient's response during a given period of time.

Purchase of Services/Contractual - the provision of services through a written agreement with other providers of services.

Registered Nurse - a person who is currently licensed in the State of Illinois, performing any act requiring substantial specialized knowledge, judgment and nursing skill, based upon the principles of psychological, biological, physical and social sciences in the application of the nursing process.

Social Work Assistant - a person who: (1) has a baccalaureate degree in social work, psychology, sociology or other field related to social work and has had at least one year of social work experience in a health care setting; or (2) has two years of appropriate experience as a social work assistant and has achieved a satisfactory grade on a proficiency examination conducted, approved or sponsored by the US Public Health Service, except that such determinations of proficiency do not apply with respect to persons initially licensed by a state or seeking initial qualification as a social work assistant after December 31, 1977.

Social Worker - a person who has a master's degree from a school of social work accredited by the Council on Social Work Education, currently licensed in the State of Illinois, and has one year of social work experience in a health care setting.

Speech Pathologist or Audiologist - a person who: (1) meets the education and experience requirements for a Certificate of Clinical Competence in the appropriate area (speech pathology or audiology) granted by the American Speech and Hearing Association; or, (2) meets the educational requirements for certification and is in the process of accumulating the supervised experience required for certification.

Subdivision - a component of a multi-function health agency, such as the home care department of a hospital or the nursing division of a health department, which independently meets the federal conditions of participation for home health agencies. A subdivision which has subunits and/or branches is regarded as a parent agency.

Subunit - a semi-autonomous organization, which serves patients in a geographic area different from that of the parent agency. The subunit by virtue of the distance between it and the parent agency is judged incapable of sharing administration, supervision and services.

2.0 DEFINITIONS (CONTINUED)

Summary Report - a compilation of the pertinent factors from the clinical notes and progress notes regarding a patient, which is submitted to the patient's physician.

Supervision - authoritative procedural guidance by a qualified person for the accomplishment of a function or activity with initial direction and periodic inspection of the actual act of accomplishing the function or activity. Unless otherwise provided, the supervisor must be on the premises if the person does not meet qualifications for assistants specified in the definitions in this section.

3.0 ADMINISTRATION/ORGANIZATION

3.01 Governing Body

The home health agency shall have a governing body or a clearly defined body having legal authority and responsibility for the conduct of the home health agency. Where the governing body of a large organization is functionally remote from the operation of the home health agency, the Department may approve the designation of an intermediate level "governing body." For the purposes of this section the governing body shall:

1) Have bylaws or the equivalent which shall be reviewed annually and be revised as needed. They shall be made available to all members of the governing body and of the professional advisory group. The bylaws or the equivalent shall specify the objectives of the agency.
2) Appoint the members of the professional advisory group.
3) Employ a qualified administrator.
4) Adopt and revise as needed policies for the operation and administration of the agency.
5) Meet at least twice a year to review the operation of the agency.
6) Keep minutes of all meetings.

3.02 Professional Advisory Group

1) The professional advisory group shall assist in developing and recommending policies and procedures for administration and home health services provided by the home health agency. These policies shall be in accordance with the scope of services offered by the agency and based on the home health needs of the patient. Policies shall be reviewed and revised annually and as needed to determine their adequacy and suitability for directing agency personnel in providing services. The policies shall include but not be limited to:
   a) Administration and supervision of the agency and home health services it provides.
   b) Criteria for acceptance, non-acceptance and discharge of patients.
   c) Home health services.
   d) Medical supervision and plans of treatment.
   e) Patient care plans.
   f) Clinical records.
   g) Personnel information.
   h) Job descriptions.
   i) Program evaluation.
   j) Coordination of services.

2) The group shall keep minutes of its meetings and meet at least quarterly to assist in developing and recommending policies and procedures for administration of the agency and for home health services provided by the agency.

3.03 Administration
The home health agency shall have written administrative policies and practices to insure the provision of safe and adequate care of the patient and shall show evidence of sufficient liability insurance.

3.04 Agency Supervision
1) The home health agency shall designate a physician or nursing director to supervise the agency's home health services. Such services shall be provided in accordance with the orders of the physician responsible for the care of each patient and under a plan of treatment established by such physician.

2) The nursing service of a home health agency shall be under the professional supervision of a full time qualified registered nurse.

3.05 Personnel Policies
1) Personnel policies available to all full and part time employees shall include but not be limited to the following.
   a) Wage scales, hours of work, vacation and sick leave.
   b) Requirement for a preemployment health examination and periodic reexaminations as required by the governing body.
   c) Plan for orientation of all health personnel to the policies and objectives of the agency.
   d) Job descriptions for all employees.
   e) Annual performance evaluation for all employees.
   f) Compliance with all applicable requirements of the Civil Rights Act of 1964.
   g) Personnel folders for all employees which shall include name and address of employee, social security number, date of birth, name and address of next of kin or guardian, job description, evidence of qualifications, sufficient liability insurance, licensure and/or registration if applicable, contracts if applicable, dates of employement and separation from the agency and reason for separation.
2) Home health agencies which provide physical therapy, occupational therapy, speech therapy, medical social work, nutritional assessment and counseling, or other services requiring the use of professionally prepared personnel, shall ensure that these services are provided or supervised by qualified personnel of the agency. There shall be adequate staffing by such qualified personnel to provide the services and administrative support required by the agency.

4.0 STAFFING/RESPONSIBILITIES

4.01 Administrator
The administrator shall have the following responsibilities on a full time basis:
1) Be familiar with the rules of the Department and maintain them within the agency.

2) Be responsible for familiarizing the employees with the law and the rules of the Department and shall have copies of the rules available for their use.
3) Be responsible for the completion, maintenance and submission of such reports and records as required by the Department.
4) Be responsible to the governing body or designee and maintain ongoing liaison with the governing body, professional advisory group, staff and community.
5) Maintain a current organizational chart to show lines of authority to the patient level.
6) Have authority and responsiblity for the management of the business affairs and the overall operation of the agency.
7) Maintain appropriate personnel records, policies and procedures of the agency.
8) Employ qualified personnel in accordance with job descriptions.
9) Provide orientation of new staff, regularly scheduled in-service education programs and opportunities for continuing educational experience for the staff.
10) Maintain an office facility for the agency large enough for efficient staff work, adequately equipped and which provides a safe working environment, meeting local ordinances and fire regulations.
11) Designate an appropriate professional employee to be the authorized representative in the absence of the administrator.

4.02 Diet Counseling Personnel
When an agency provides or arranges for diet counseling services, these services shall be given in accordance with a physician's orders, and by or under the supervision of a qualified dietitian. Diet counseling personnel shall perform but shall not be limited to the following duties:
1) Assist the physician in evaluating the dietary needs of the patient.
2) Help the patient understand, accept and follow dietary modifications ordered by the physican.
3) Observe, record and report to the physician the patient's reaction to dietary treatment and any related changes in the patient's condition.
4) Instruct, supervise and/or counsel other members of the health care team including, when appropriate, home health aides and family members regarding the dietary care of the patient.

4.03 Home Health Aide
Responsibilities of the home health aide shall include but not be limited to:
1) The home health aide shall perform only those personal care activities contained in a written assignment by a health professional employee which include assisting the patient with personal hygiene, ambulation, eating, dressing and grooming.

2) The home health aide may perform other activities as taught by a health professional employee for a specific patient.
3) The home health aide shall not change sterile dressings, irrigate body cavities, irrigate a colostomy or wound, perform a gastric lavage or gavage, catheterize a patient, administer medications, apply heat by any method, care for tracheostomy tube, or perform any personal health service which has not been included by the registered nurse in the patient care plan.
4) The home health aide shall keep records of personal health care activities.
5) The home health aide shall observe appearance and gross behavioral changes in the patient and report to the registered nurse.
6) The home health aide shall be supervised in the home by the appropriate supervisor at least every two weeks.
7) The agency shall maintain a ratio of at least one health professional employee for every five nonprofessional persons providing health services. When full time equivalents are used in the case of part time nonprofessional persons providing health services, the actual number of such persons supervised shall not exceed twelve.

4.04 Homemaker
Responsibilities of the homemaker shall include but not be limited to:
1) The homemaker shall maintain the home in an optimum state of cleanliness and safety.
2) The homemaker shall perform the functions generally undertaken by the natural homemaker, including such duties as preparation of meals, laundry, shopping and care of children.
3) The homemaker shall report to the appropriate supervisor any incidents or problems related to her work or to the family.
4) The homemaker shall maintain appropriate work records.
5) The homemaker shall be supervised in the home by the appropriate supervisor at least once a month.

4.05 Licensed Practical Nurse
1) The licensed practical nurse may perform selected acts, including the administration of treatments and medications, in the care of the ill, injured, or infirm, the maintenance of health and prevention of illness of others, under the direction of a registered nurse.
2) The licensed practical nurse shall report changes in the patient's condition to her immediate supervisor with the reports documented in the clinical notes.
3) The licensed practical nurse shall prepare clinical notes for the clinical record.

4.06 Medical Social Worker
The medical social worker shall:
1) Assist the physician and other members of the health team in understanding significant social and emotional factors related to the patient's health problems.

2) Assess the social and emotional factors in order to estimate the patient's capacity and potential to cope with problems of daily living.
3) Help the patient and family to understand, accept and follow medical recommendations and provide services planned to restore the patient to optimum social and health adjustment within the patient's capacity.
4) Assist patients and their families with personal and environmental difficulties which predispose toward illness or interfere with obtaining maximum benefits from medical care.
5) Utilize resources, such as family and community agencies, to assist patient to resume life in the community or to learn to live within the disability.

4.07 Occupational Therapist and Occupational Therapy Assistant
1) The occupational therapist shall:
a) Assist the physician in evaluating the patient's level of function by applying diagnostic and prognostic procedures.
b) Guide the patient in his use of therapeutic creative and self-care activities for the purpose of improving function.
c) Observe, record and report to the physician the patient's reaction to treatment and any changes in the patient's condition.
d) Instruct other health team personnel including, when appropriate, home health aides and family members in certain phases of occupational therapy in which they may work with the patient.
2) Occupational therapy assistant responsibilities shall be those of assisting the licensed occupational therapist in an occupational therapy program.

4.08 Physical Therapist and Physical Therapy Assistant
1) The physical therapist shall:
a) Assist the physician in evaluating patients by applying diagnostic and prognostic muscle, nerve, joint and functional abilities test.
b) Treat patients to relieve pain, develop or restore function, and maintain maximum performance, using physical means, such as exercise, massage, heat, water, light and electricity.
c) Observe, record and report to the physician the patient's reaction to treatment and any changes in the patient's condition.
d) Instruct patient in care and use of wheelchairs, braces, crutches, canes and prosthetic and orthotic devices.
e) Instruct other health team personnel including, when appropriate, home health aides and family members in certain phases of physical therapy with which they may work with the patient.
f) Instruct family on patient's total physical therapy program.
2) Physical therapist assistant responsibilities shall be directed by a licensed physical therapist.

4.09 Speech Therapist

The speech therapist shall:

1) Assist the physician in evaluation of the patient to determine the type of speech or language disorder and the appropriate corrective therapy.
2) Provide rehabilitative services for speech and language disorders.
3) Record and report to the physician the patient's reaction to treatment and any changes in the patient's condition.
4) Instruct other health team personnel and family members in methods of assisting the patient or improve and correct speech disabilities.

4.10 Staff Nurse

1) The staff nurse shall:
   a) Have the responsibility for observation, assessment, nursing diagnosis, counsel, care and health teaching of the ill, injured or infirm, and the maintenance of health and prevention of illness of others.
   b) Maintain a clinical record for each patient receiving care.
   c) Provide progress reports to the attending physicians about patients under care when the patients' conditions change or there are deviations from the plan of care or at least every 60 days.
2) The staff nurse may:
   a) Make home health aide assignments and supervise the aide in the home.
   b) Direct a licensed practical nurse.
   c) Administer medications and treatments as prescribed by a physician.

4.11 Supervising Nurse

1) The supervising nurse shall:
   a) Supervise all staff nurses and home health aides.
   b) Insure that the professional standards of community nursing practice are maintained by all nurses provided care.
   c) Be responsible for maintaining and adhering to agency procedure and patient care policy manuals.
   d) Be responsible for the direct supervision of no more than 10 full time nursing service personnel. When full time equivalents are used in the case of part time personnel, the actual number of persons supervised shall not exceed 15.
2) In the event the agency director is not a health professional, the supervising nurse shall, in addition to the above:
   a) Establish service policies and procedures in compliance with state statutes.
   b) Employ and evaluate nursing personnel.
   c) Coordinate patient care services.

d) Set policies for, and keep records of, case assignments and case management.
e) Prepare and maintain a schedule of those cases to be brought to the utilization review committee.
f) Conduct selective program evaluations to improve deficient services and develop and implement plans.

5.00 SERVICES

5.01 Services Provided

1) Each agency shall provide professional nursing and at least one other therapeutic service. The professional nursing shall be provided directly by agency staff. Other therapeutic services may be provided by agency staff directly or provided under arrangements.
2) The agency's objectives shall state explicitly what services will be provided directly and what services will be provided under arrangements.
3) Services provided under arrangements shall be through a written agreement which includes but is not limited to the following:
   a) Services to be provided.
   b) Provision for adherence to all applicable agency policies and personnel requirements.
   c) Designation of full responsibility for agency control over contracted services.
   d) Procedures for submitting clinical and progress notes.
   e) Charges for contracted services.
   f) Evidence of liability and insurance coverage.
   g) Period of time in effect.
   h) Date and signatures of appropriate authorities.
   i) Provision for termination.

5.02 Acceptance of Patients

Patient acceptance and discharge policies shall include but not be limited to the following:

1) Persons shall be accepted for health service only upon a plan of treatment established by the attending physician reduced to writing within seven days.
2) No person shall be refused service because of age, race, color, sex, national origin or payment source.
3) When a person is accepted for health service, there shall be a reasonable expectation that the person's medical, nursing, dietary, physical and/or social needs can be met adequately and safely in his residence.
4) When services are to be terminated, the patient is to be notified three working days in advance of the date of termination and reason for termination which shall be documented in the clinical record. A plan shall be developed or a referral made for any continuing care indicated.

5) Services, except homemaker services, shall not be terminated until such time as the patient's physician and the professional person providing care mutually concur or arrangements are made for continuing care.

5.03 Plan of Treatment

1) Skilled nursing and therapeutic treatment shall be in accordance with a plan based on the patient's diagnosis and the assessment of the patient's diagnosis and the assessment of the patient's immediate and long range needs and resources. The plan of treatment is established in consultation with the home health services team which includes the attending physician, pertinent members of the agency staff, the patient and members of the family. The plan of treatment shall include:
   a) Diagnoses and surgery with dates relevant to the provision of home health services.
   b) Functional limitations and rehabilitation potential.
   c) Expected outcomes for the patient.
   d) The attending physician's regimen of:
      (1) Medications
      (2) Treatments
      (3) Activity
      (4) Diet
      (5) Specific procedures deemed essential for the health and safety of the patient.
   (e) The attending physician's signature.

(2) Consultaton with the primary care physician or designate on any modifications in the plan of treatment deemed necessary by the staff shall be noted, and the physician's or alternate's signature obtained within seven days of any modification of the medical plan of treatment.

3) The plan shall be reviewed by the home health services team every 60 days or more often should the patient's condition warrant.

4) There shall be a written or verbal summary of the patient's status and a revised plan of treatment given to the physician for his review/revision and signature every 60 days or more often as indicated.

5.04 Plan for Home Health Services

1) Home health services from members of the agency staff shall be offered in accordance with the plan of treatment and the plan for home health services. The plan for home health services shall be written by professional members of the agency based upon the plan of treatment and a written assessment of the patient's needs, resources, family and environment. The initial assessment is to be made by a registered nurse. Assessments by other health team members will be made on orders of the physician or by request of a registered nurse.

2) The plan for home health services shall be updated as often as the patient's condition indicates. The plan will be maintained as a permanent part of the patient's record. The plan for home health services shall indicate:
   a) Patient problems.
   b) Patient's goals, family's goals, service goals.
   c) Service approaches to modify or eliminate problems.
   d) Anticipated outcome of services approaches.
   e) Estimated timeframe.
   f) The professional staff responsible for a given element of service.
   g) A list of all medications used by the patient and why the patient uses them, with notation of possible side effects and incompatibilities of the medications.
   h) Review and updating of the medications list once every 60 days, or whenever there is any change in prescription or nonprescription medications.

5.05 Clinical Records

Each patient shall have a clinical record, identifiable for home health services and maintained by the agency in accordance with accepted professional standards. All records shall contain:

1) Appropriate identifying information for the patient, household members and caretakers, medical history and current findings.
2) A plan for home health services for the patient developed by the agency's health team which is in accord with the physician's plan of treatment.
3) A current medication list.
4) Initial and periodic patient assessments by the registered nurse which must include documentation of the patient's functional status and eligibility for service.
5) Assessments made by other professional personnel.
6) Signed and dated clinical notes for each contact which are written the day of service and incorporated into the patient's clinical record at least weekly.
7) Reports of all patient home health service conferences.
8) Reports of contacts with physicians by staff and patients.
9) Indication of supervision of home health services by the supervising nurse, a registered nurse, or other professional health personnel.
10) A discharge summary giving a brief review of service, patient status, reason(s) for discharge, and plans for post discharge needs of the patient.
11) A copy of the patient transfer information sheet, if patient is admitted to a health facility or transferred to another health agency.
12) Records for patients requiring skilled nursing and/or other therapeutic services shall contain:
   a) The physician's signed plan of treatment(s).
   b) A notated medication list with dates reviewed, revised and date sent to the attending physician.

c) Written summary reports sent to the attending physician every 60 days containing home health services provided, the patient status, recommendations for revision of the plan of treatment, and the need for continuation or termination of services noted. Verbal conferences may be substituted but content must be noted in the record.

d) Written and signed confirmation of physician's interim verbal orders.

13) Each agency shall have a written policy on records procedures and shall retain records for a minimum of five years beyond the last date of service provided.

14) Each agency shall have a written policy and procedures for the protection of confidentiality of patient records which explains the use of records, removal of records and release of information.

5.06 Administration of Drugs and Biologicals

The agency shall have policies governing the administering of drugs and biologicals which shall include but not be limited to the following:

1) All orders for medications to be given by the agency health professional staff shall be dated and signed by the attending physician.

2) All orders for medications shall contain the name of the drug, dosage, frequency, method or site of injection and permission from the physician if the patient and/or family are to be taught to give medication.

3) Nurses shall not carry drugs, except for an emergency kit, including syringes, needles, combination airway and agency approved drug for use should the patient have a severe drug reaction.

4) All verbal orders for medication or change in medication orders shall be taken by the appropriate health professional and reduced to writing and signed by the physician within seven days.

5) Experimental drugs, sera, allergenic desensitizing agents, penicillin or any other potentially hazardous drug shall not be given without the fully informed consent of the patient or family. The nurse administering such drugs shall have an emergency plan and whatever drugs and/or devices are appropriate in reversal of a drug reaction.

5.07 Evaluation

The home health agency shall have written policies and are required to make an overall evaluation of the agency's total program at least once a year by the group of professional personnel (or a committee of this group), home health agency staff, and professional people outside the agency. The evaluation consists of an overall policy and administrative review and a clinical record review. The evaluation shall assess the extent to which the agency's program is appropriate, adequate, effective and efficient. Results of the evaluation shall be reported to and acted upon by those responsible for the operation of the agency and are maintained separately as administrative records.

5.08 Policy and Administrative Review
As a part of the evaluation process the policies and administrative practices of the agency are reviewed to determine the extent to which they promote patient care that is appropriate, adequate, effective and efficient. Mechanisms are established in writing for the collection of pertinent data to assist in evaluation. The data to be considered may include but are not limited to: number of patients receiving each service offered, number of patient visits, reasons for discharge, breakdown by diagnosis, sources of referral, number of patients not accepted with reasons and total staff days for each service offered.

5.09 Clinical Record Review
At least quarterly, appropriate health professionals, representing at least the scope of the program, review a sample of both active and closed clinical records to assure that established policies are followed in providing services (direct services as well as services under arrangement). There is a continuing review of clinical records for each 60 day period that a patient received home health services to determine adequacy of the plan of treatment and appropriateness of continuation of care.

5.10 Annual Report
The annual report submitted to the Department will be utilized in evaluating an agency's performance and become part of the relicensure process. For the list of items to be included in the annual report, see Section 6.09 2) Renewal of License.

6.0 LICENSURE

6.01 License Required
1) No person shall open, manage, conduct or maintain a home health agency without a license issued by the Department.
2) A person shall make application for and receive a license from the Department, which shall be based upon compliance with all applicable laws, rules and regulations.
3) Separate licensure, applications and fees for operation of a home health agency are required for all home health agency subunits.

6.02 Provisional Licensure
1) Any person opening, managing, conducting or maintaining a home health agency during the year beginning October 1, 1977, upon proper application and payment of the fee of $25.00 shall be issued a provisional licensure which shall expire on September 30, 1978.

2) Each application for a home health agency provisional license shall contain the following information: 1) name, address and location of agency; 2) organization and governing structure of agency; 3) number and qualification of staff; 4) sources of financing of services and agency; 5) service area; 6) patient load; 7) agency utilization; 8) service charges; 9) affiliation agreements with other health care providers; and 10) such other information as the Department may require.
3) Applications for licenses to be effective on and after March 1, 1978, shall be in accordance with these regulations.

6.03 Exemptions
1) This Act does not apply to any home health agency conducted by and for the adherents of any well recognized church or religious denomination for the purpose of providing services for the care or treatment of the sick who depend upon prayer or spiritual means for healing in the practice of the religion of such church or religious denomination.

6.04 Expiration
1) Each license shall be for a term of one year and shall expire one year from the date of issuance.
2) The licensee shall notify the Department 30 days in advance of closing the home health agency.

6.05 License Nontransferable
1) Each license shall be issued only for the home health agency named in the application and shall not be transferred or assigned to any other person, agency or corporation.
2) Sale, assignment, lease or other transfer, voluntary or involuntary, shall require relicensure by the new owner or person in interest prior to maintaining, operating or conducting a home health agency.

6.06 Application Procedure
1) On and after October 1, 1978, an annual license shall be issued to any person upon a signed application and payment of the fee, if standards established by the Department and other requirements of the Act and these regulations are met.
2) The fee for each license or any renewal shall be $25.00. The fee shall accompany the filing of the application and is not refundable. A fee of $25.00 is required for each subunit operated by the home health agency.
3) At the time of application for licensure, a proposed home health agency must present written proof of approval from the Health Systems Agency having jurisdiction in the geographic service area in which it intends to operate.
   a) If the proposed home health agency intends to operate in more than one Health Service Area, it must present written evidence of mutual approval by all Health Systems Agencies having jurisdiction.

b) If an existing home health agency proposes to expand its service area beyond its currently approved service area, it must have prior written approval from the Health Systems Agency or agencies having jurisdiction. The information to be considered for service area expansion shall be same as that required for a de novo application.

In considering a proposed home health agency for approval or disapproval, the Health Systems Agency may consider the following:

(1) Type(s) of service to be offered.
(2) Geographic area to be served.
(3) Financial viability of proposed home health agency.
(4) Types of patients to be served.
(5) Existence of other home health agencies in area.
(6) Impact on existing home heatlh agencies now serving area.
(7) Adequacy in scope and quantity of services now being provided.
(8) Estimated per cent of need now being met by existing home health agencies.
(9) Feasibility of existing home health agencies expanding to meet need.
(10) Such other factors as the Health Systems Agency deems pertinent to its Health Service Area.

d) The Health Systems Agency may conduct a public hearing for each home health agency application.

e) Home Health Agencies approved by the Health Systems Agency should be reviewed annually by the Health Systems Agency to provide assurance that they are performing in the manner stated in the original application.

f) The report of any such review shall be submitted annually to the Department at least 30 days prior to the expiration of the Agency's current license.

g) Failure to operate as proposed in the application for approval from the Health Systems Agency may result in denial of licensure.

4) A person desiring to obtain a license shall file with the Department an application on a form prescribed, prepared and furnished by the Department. The application shall contain such information as may be required by the Department for the proper administration and enforcement of the Act and these regulations.

5) A person in interest, different from the licensee, contemplating conducting, maintaining or operating a home health agency pursuant to Section 6.05 2) of these regulations, shall file an application for licensure with the Department.

6.07 Financial Statements Required

1) Each licensee shall file annually, or more often as the Director shall prescribe, an attested financial statement on a form prescribed, prepared and furnished by the Illinois Department of Public Health in conjunction with the Illinois Department of Public Aid. The application shall contain such information as may be required by the Illinois Department of Public Health and the Illinois Department of Public Aid for the proper administration of the Act and these regulations. An audited financial statement may be required of a particular facility, if the Director determines that additional information is needed.
2) No public funds shall be expended for the services of a home health agency which has failed to file the financial statement required by this section.
3) No other state agency may require submission of financial data except as expressly authorized by law or as necessary to meet requirements of federal law or regulation.
4) Information obtained under this section shall be made available, upon request, by the Department to any other State agency or legislative commission to which such information is necessary for investigations or to execute the intent of state or federal law or regulation.

6.08 Denial of License

1) An application for a license may be denied for any of the following reasons:
   a) Failure meet the minimum standards prescribed by the Department.
   b) Satisfactory evidence that the moral character of the applicant or supervisor of the agency is not reputable. In determining moral character, the Department may take into consideration any convictions of the applicant or supervisor but such convictions shall not operate as a bar to licensing.
   c) Lack of personnel qualified by training and experience to properly perform the function of a home health agency.
   d) Insufficient financial or other resources to operate and conduct a home health agency in accordance with the requirements of this Act and the minimum standards, rules and regulations promulgated thereunder.
   e) The agency does not receive approval from the Health Systems Agency in the area.
2) The Department may, upon its own motion, and shall upon the verified complaint, in writing, of any person setting forth facts which if proven would constitute ground for the denial of an application for a license, notify the applicant in the manner set forth in Section 6.12 of these regulations.

6.09 Renewal of License

1) An application for renewal of license shall be filed with the Department at least 60 days prior, but no sooner than 90 days before the expiration date of the currently held license.

2) Each agency shall submit an annual report to the Department within 90 days after the close of agency's fiscal year. The annual report will become one of several items utilized in determining an agency's status for renewal of license.

The following information shall be included:

a) Financial statement.
b) Full disclosure of agency ownership.
c) Total number of admissions and discharges.
d) Total number of admissions and discharges receiving services directly.
e) Total number of persons receiving services directly from each individual discipline, including home health aides and homemakers.
f) Total number of visits provided directly by each individual discipline, including home health aides and homemakers.
g) Total number of admissions and discharges receiving services under arrangements.
h) Total number of persons receiving services under arrangements from each individual discipline including home health aides and homemakers.
i) Total number of visits provided under arrangement by each individual discipline including home health aides and homemakers.
j) Number and type of personnel in agency.
k) Staffing patterns.
l) Costs per patient visit by type of service.
m) Average number of visits per patient.
n) Age distribution of patients served.
o) Number of patients in each age category.
p) Number of patients served by disease category.
q) Sources of income by percentage distribution according to income category.
r) Such other information as the Department may request.

6.10 Renewal of License Denied

1) An application for a renewal of license may be denied for any of the following reasons:
   a) A violation of any provision of the Act or of the minimum standards, rules, regulations or orders of the Department promulgated thereunder;
   b) Any ground upon which an application for a license may be denied as set forth in Section 6.08 1) of this regulation.
2) The Department may, upon its own motion, and shall upon the verified complaint, in writing, of any person setting forth facts which if proven would constitute grounds for the denial of an application for a license, notify the applicant in the manner set forth in Section 6.12 of these regulations.

6.11 Revocation of License

1) A license may be revoked for any of the following reasons:
   a) A violation of any provision of the Act or of the minimum standards, rules, regulations or orders of the Department promulgated thereunder;
   b) Any ground upon which an application for a license may be denied as set forth in Section 6.08 1) of these regulations.
2) Conduct or practice found by the Director of the Department to be detrimental to the health, safety or welfare of a patient is grounds for revocation of a license.
3) The Department may, upon its own motion, and shall upon the verified complaint, in writing, of any person setting forth facts which if proven would constitute grounds for the denial of an application for a license in the manner set forth in Section 6.12 of these regulations investigate the applicant or licensee.
4) In the event that an immediate and serious danger to the public health, safety and welfare exists, the Director may order an emergency suspension of a license. Emergency suspension may be ordered but revocation proceedings shall thereafter be promptly instituted.

6.12 Investigation, Notice and Hearing

1) Licenses issued by the Department to operate home health agencies, will be based, in part, upon the results of a survey and inspection conducted by Department representatives to determine compliance with the requirements of the Act and these regulations.
2) Any duly authorized officer or employee of the Department shall have the right to make surveys and inspections as are necessary in order to determine the status of compliance with the provisions of this Act and this regulation.
3) The Department may, upon its own motion, and shall upon the verified complaint in writing of any person setting forth facts which if proven would constitute grounds for the denial of an application for a license, or refusal to renew a license, or revocation of a license, investigate the applicant or licensee.
4) Before denying an application or refusing to renew a license or revoking a license, the Department shall notify the applicant or licensee.
5) Notice shall be effected by registered mail or by personal service setting forth the particular reasons for the proposed action and fixing a date, not less than 15 days from the date of such mailing or service, at which time the applicant or licensee shall be given an opportunity for a hearing.
6) Such hearing shall be conducted by the Director or by an employee of the Department designated in writing by the Director as Hearing Officer to conduct the hearing.
7) On the basis of any such hearing or upon default of the applicant or licensee, the Director shall make a determination specifying his findings and conclusions.

8) The procedure governing hearings authorized by this section shall be in accordance with the Illinois Administrative Procedure Act which is expressly adopted and incorporated herein as if all of the provisions of such Act were included in this Act, except that in case of conflict between the two Acts the provisions of this Act shall control.

9) The Director or Hearing Officer shall upon his own motion on on the written request of any party to the proceeding, issue subpoenas requiring the attendance and the giving of testimony by witnesses and subpoenas duces tecum requiring the production of books, papers, records or memoranda. All subpoenas and subpoenas duces tecum issued under the terms of this Act may be served by any person of full age. The fees of witnesses for attendance and travel shall be the same as the fees of witnesses before the circuit court of this state, such fees to be paid when the witness is excused from further attendance. When the witness is subpoenaed at the instance of the Director, or Hearing Officer, such fees shall be paid in the same manner as other expenses of the Department, and when the witness is subpoenaed at the instance of any other party to any such proceeding the Department may require that the cost of service of the subpoena or subpoena duces tecum and the fee of the witness be borne by the party at whose instance the witness is summoned. In such case, the Department in its discretion, may require a deposit to cover the cost of such service and witness fees. A subpoena or subpoena duces tecum issued as aforesaid shall be served in the same manner as a subpoena issued out of a court.

10) Any circuit court of this state upon the application of the Director, or upon the application of any other party to the proceeding, may, in its discretion, compel the attendance of witnesses, the production of books, papers, records or memoranda and the giving of testimony before the Director or Hearing Officer conducting an investigation or holding a hearing authorized by this Act, by an attachment for contempt, or otherwise, in the same manner as production of evidence may be compelled before the court.

11) The Director or Hearing Officer, or any party in an investigation or hearing before the Department, may cause the depositions of witnesses within the state to be taken in the manner prescribed by law for like depositions in civil actions in courts of this state, and to that end compel the attendance of witnesses and the production of books, papers, records or memoranda.

6.13 Applicant's Right to Administrative Review

1) Whenever the Department denies an application for a license, refuses to renew a licene, revokes a license, or suspends a license to open, conduct, operate or maintain a home health agency, the applicant or licensee may have such decision judicially reviewed. The provisions of the "Administrative Review Act," approved May 8, 1945, as heretofore or hereafter amended, and the rules adopted pursuant thereto shall apply to and govern all proceedings for the judicial review of final administrative decisions of the Department hereunder. The term "administrative decisions" is defined as in Section 1 of the "Administrative Review Act."

mf/D/P3

NOTICE BY THE ILLINOIS DEPARTMENT OF INSURANCE

REGARDING PROPOSED RULE 56.01

RELIGIOUS AND CHARITABLE RISK POOLING TRUSTS

NOTICE

The Illinois Department of Insurance proposes Rule 56.01 to implement the provisions of the Charitable Risk Pool Trust Act as created by Public Act 80-530 (Senate Bill 792, 80th General Assembly).

This Act permits organizations which are exempt from taxation under sub-section 3 of paragraph (c) of Section 501 of the Internal Revenue Code of 1954 to establish or become beneficiaries of a trust fund for the purpose of providing protection against the risk of financial loss due to damage, destruction or loss of property or the imposition of legal liability upon written application and prior approval of the Director of Insurance.

The Director of Insurance must withhold approval of any trust instrument which does not comply with the provisions of the Act or any Rule or Regulation promulgated thereunder. Therefore, the Department of Insurance is proposing Rule 56.01 to establish standards for the establishment, operation and administration of trusts authorized under the Act.

The proposed Rule deals with the following subject matters: documents required to be filed with the trust instrument; residency requirements; financial and performance examinations; benefit schedules; standards of solicitation and advertising; authorized investments; filing of financial statements; provisions for liquidation; procedures for amending the trust instruments; pooling among several trusts; and requirements of trust administrators.

The Director of Insurance will conduct a hearing with respect to proposed Rule 56.01 on February 3, 1978 in Room 1600, State of Illinois Building, 160 North LaSalle Street, Chicago, Illinois from 9:30 A.M. to 12:00 noon and from 1:30 P.M. to 4:30 P. M. All interested persons who wish to present their views, comments and data concerning this Rule may do so by attending this hearing or by sending written comments to the attention of Mr. Kim M. Brunner, Department of Insurance, 213 East Monroe Street, Springfield, Illinois 62767. All interested persons

who wish to present their views orally under oath at the hearing must notify the Director of Insurance no later than 5:00 P.M. on February 1, 1978. Any person who fails to file a timely notice will not be permitted to offer oral views except as time permits.

The complete text of proposed Rule 56.01 follows.

Rule 56.01 Religious and Charitable Risk Pooling Trust

Section 1. Authority and Scope.

This Rule is promulgated by the Director of Insurance pursuant to Section 20 of the Religious and Charitable Risk Pool Trust Act (Illinois Revised Statutes), hereinafter the Act, which empowers the Director of Insurance to "make reasonable rules and regulations as may be necessary for the administration "of the Act". The purpose of this Rule is to establish standards for the establishment, operation and administration of trusts authorized by the Act.

Section 2. Applications for Approval.

A. Any person filing a trust instrument for approval of the Director of Insurance pursuant to the Act shall file duplicate originals containing the following:

1. the trust instrument together with all necessary exhibits.

2. a proposed benefit schedule, including all contribution requirements of each beneficiary.

3. detailed biographies of all trustees including educational experience, professional designations and criminal convictions.

4. identification of independent CPA for auditing purposes and a copy of the letter of engagement.

5. a letter of transmittal which identifies an individual to whom all official notices, correspondence and complaints may be sent.

6. copies of the certificates of authorities of each of the proposed beneficiaries.

7. all solicitation and/or advertising materials.

B. The trust instrument shall be in writing and shall be executed and in addition to the requirements contained in the Act shall contain provisions addressing the following:

1. a requirement that the trust itself may not be effective until written approval is granted by the Director of Insurance.

2. a requirement that the administrators, offices and funds of the trust be located within Illinois, including a requirement that the funds shall be deposited only in a national or state bank with appropriate trust powers located in Illinois.

3. a requirement that all beneficiaries be residents of the State of Illinois and have their operations confined solely to Illinois. It is the specific intention of this requirement to restrict the use of the Act only to charities and religious entities located and operating exclusively in the State of Illinois.

4. a requirement that each beneficiary supply the appropriate documentation from the Internal Revenue Service permitting tax exempt status in accordance with Section 501c(3) of the Internal Revenue Code of 1954 as amended to be included in the permanent records of the trust.

5. a requirement that the trust be audited yearly by an independent certified public accountant and that the audit be conducted in accordance with standards applicable to trust entities promulgated by the American Institute of Certified Public Accountants.

6. a requirement that all insurance policies or programs purchased by the trust be purchased only from insurance companies authorized to do business within the State of Illinois including those companies authorized as surplus lines carriers.

7. a requirement that should liquidation of the trust be necessary, liquidation will be carried out in accordance with the provisions and standards of Article XIII of the Illinois Insurance Code.

Section 3. Examinations.

All trusts established and approved pursuant to the Act shall be subject to financial and/or performance examinations conducted by the Director of Insurance as often as he shall deem necessary. The examinations shall be conducted in accordance with the provisions of Sections 132, 401, 402 and 403 of the Illinois Insurance Code. All books, records, correspondence and papers of each trust shall be available for examination at any time and shall be located within the State of Illinois.

Section 4. Benefit Schedules.

A. Each trust established and approved pursuant to the Act shall establish benefit schedules for each type of protection against the risk of financial loss available to each beneficiary. Each benefit schedule shall clearly indicate that evaluations of each request for payment shall be conducted in accordance with a standardized written procedure. Each beneficiary shall receive the appropriate benefit schedule together with any amendments or modifications made to those schedules.

B. All benefits payable in accordance with the benefit schedules shall be subject to all claims practice standards contained in the Illinois Insurance Code and any Rule promulgated thereunder. The trust administrator shall maintain a file for each payment request made by each beneficiary and the file shall contain all relevant documents necessary to clearly reconstruct all events surrounding the request for payment.

Section 5. Solicitation and Advertising.

East trust approved pursuant to the Act shall solicit beneficiaries in accordance with the following standards:

A. No solicitation or advertising material may contain any indication that the trust program or beneift schedule is endorsed by the Illinois Department of Insurance.

B. The words, "insurance", "indemnity", "insurance trust", or any other similar words may not be used in any solicitation or advertising material.

C. Each solicitator shall be a salaried employee of the trust or trust administrator and shall be subject to examination by the Director of Insurance.

Section 6. Investments.

Each trust approved pursuant to the Act shall invest its funds only in securities permitted by the law of this State for the investment of assets by life insurance companies. All such investments shall be subject to valuation in accordance with Section 124.6 of the Illinois Insurance Code.

Section 7. Financial Statements.

Each trust approved pursuant to the Act shall file audited financial statements in accordance with the requirements of Section 14 of the Act audited by an independent certified public accountant designated in the application required by Section 2 of this Rule. The statements submitted shall be prepared in the form applicable for trust entities recommended by the American Institute of Certified Public Accountants. The auditing standards to be employed shall be those recommended by the American Institute of Certified Public Accountants. In addition to any other materials recommended by the American Institute of Certified Public Accountants, the financial statements shall contain the following:

A. A balance sheet listing all assets and liabilities.

B. A statement of income, expenses and fund balance.

C. A complete and detailed listing of each investment or asset held, such listing similar to the appropriate investment schedules contained in the Convention Annual Statement of the National Association of Insurance Commissioners for insurance companies.

D. All appropriate notes to the financial statements, including any and all litigation involving the trust.

The statement shall disclose any and all liability of the trust and provide for an estimate of the ultimate net cost of all losses and related loss adjustment expenses incurred as of the statement date.

Section 8. Liquidation.

East trust is required to adhere to the standards of financial solvency set forth in Article XIII of the Illinois Insurance Code. Should the Director, within his discretion and based upon examination or investigation, determine that any trust is no longer adhering to the standards of financial solvency, he may undertake proceedings in accordance with Article XIII of the Illinois Insurance Code to liquidate the trust entity.

Section 9. Amendments to the Trust Instrument.

A. All amendments or modifications to the originally approved trust instrument shall be made in writing and filed in duplicate with the Director of Insurance and approved by the Director of Insurance prior to their taking effect.

B. All trustees selected as successor to the original trustees set forth in the application required by Section 2 of this Rule shall submit complete biographical data to the Director of Insurance within 14 days of their appointment. This requirement may be satisfied by the filing of such data by the trust or trust administrator and shall be kept as a part of the permanent records of the trust.

Section 10. Pooling Among Several Trusts.

A. No trust established and approved pursuant to the provisions of this Act shall enter into any written agreements with any other trust fund for the pooling and sharing of risks unless such other trust funds have been established and approved pursuant to the provisions of this Act.

B. No trust established and approved pursuant to the provisions of this Act shall pool or share risks with any other trust established by the laws of any state of the United States other than Illinois. It is the specific intention of this provision to limit the pooling and sharing of risks among religious and charitable risk pooling trusts to trust funds approved pursuant to the Act and located in Illinois.

Section 11. Administrators.

A. Each trust approved pursuant to the Act may

engage an administrator for the purpose of administrating and operating the trust fund. Such administrator must be a resident of the State of Illinois with its principal office located within the State of Illinois. Such administrator may be a natural person, partnership or corporate entity.

B. All persons administering a trust approved pursuant to the provisions of the Act shall be subject to the examination of the Director of Insurance in accordance with Section 132 of the Illinois Insurance Code and shall maintain all trust records within the State of Illinois.

C. All administrators operating a trust approved pursuant to the provisions of the Act must adhere to all standards of fiduciary conduct required by the laws of the State of Illinois and must adhere to all standards of claims practices and procedures set forth in the Illinois Insurance Code and all Rules promulgated thereunder.

Section 12. Severability.

If any provision of this Rule or the application thereof to any person or circumstance is held invalid, the invalidity shall not effect other provisions or applications of this Act which can be given affect without the invalid provision or application, and to this end the provisions of the Rule are severable.

Section 13. Effective Date.

This Rule shall be effective on the day of 1978.

Illinois Department of Public Aid - Revision of 4.03 -

Physicians' Services

The Illinois Department of Public Aid is revising rule 4.03 (Physicians' Services). On January 11, 1978, the United States Court of Appeals (7th Circuit), in the case of Zbaraz v. Quern, No. 77-2290, entered an Order prohibiting the Department from denying payments in reliance on P.A. 80-1091 to medical providers for the rendition of medical services to indigent pregnant women for therapeutic abortions. This revision implements that Order.

This Court Order adoption is made pursuant to Section 5(e) of the Administrative Procedure Act without the normal notice and hearing procedures being followed. The revision (which appears in subparagraph 1 under the "Service Limitations" section) became effective January 13, 1978, the date of filing, and will apply to services rendered on or after January 11, 1978, and for as long as the Court Order is in effect.

The text of the revised Rule 4.03 is as follows:

RULE 4.03 PHYSICIANS' SERVICES

PHYSICIAN PARTICIPATION

Payment shall be made only to physicians.

The restrictions and limitations which shall apply to physician participation include the following:

1) Interns are not eligible to participate;

2) Residents are eligible to participate where, by terms of their contract with the hospital, they are permitted to and do bill private patients and collect and retain the payments received for their services;

3) Hospital based specialists who are salaried, with the cost of their services included in the hospital reimbursement costs, are eligible to participate when their contractual arrangement with the hospital provides for them to make their own charges for professional services and they do, in fact, bill private patients and collect and retain payments made;

4) Physicians holding non-teaching administrative or staff positions in hospitals and/or medical schools are eligible to participate to the extent that they maintain a private practice and bill private patients and collect and retain payments made; and

5) Teaching physicians who provide direct patient care are eligible to particpate if the salaries paid them by hospitals or other institutions do not include a component for treatment services.

COVERED SERVICES

The Department shall pay physicians for the provision of services not otherwise excluded which are:

1) Essential for the diagnosis and treatment of a disease or injury;

2) Included in the Physicians' Common Procedural Terminology (CPT) second edition, published by the American Medical Association; and

3) Provided by the physician or by a member of the physician's staff under the physician's direct supervision.

The Department shall not pay for physicians' services in Federal or State institutions, and shall not pay for referrals.

SERVICE LIMITATIONS

When provided in accordance with the specified limitations and requirements, the Department shall pay for the following services:

1) Termination of pregnancy -- only in those cases in which the physician has certified in writing to the Department that the procedure is necessary to preserve the life of the mother (and also, effective for services on or after January 11, 1978, and for as long as the Order entered on that date by the United States Court of Appeals for the Seventh Circuit in the case of Zbaraz v. Quern, No. 77-2290, is in effect, in those cases in which a physician has certified in writing that the procedure is medically necessary or medically indicated according to the professional medical judgment of that physician, exercised in light of all facts affecting the health of the mother).

2) Sterilization --

a) Therapeutic sterilization -- only when the procedure is either a necessary part of the treatment of an existing illness, or is medically indicated as an accompaniment of an operation on the female genitourinary tract. Mental incapacity does not constitute an illness or injury in respect to this procedure.

b) Non-therapeutic sterilization -- only for recipients age 21 or older. The physician must obtain the recipient's informed written consent in a language understandable to the recipient before performing the sterilization and must advise the recipient of the right to withdraw consent at any time prior to the operation. The operation shall be performed no sooner than 72 hours following the recipient's written informed consent.

3) End stage renal disease treatment (chronic hemodialysis and kidney transplantation) -- is limited to those recipients who have been determined medically eligible for such treatment by the Illinois Department of Public Health.

4) By-pass surgery for morbid obesity -- only with the prior approval of the Department. The Department shall approve payment for this service only in those cases in which it determines that obesity is exogenous in nature, the recipient has had the benefit of other therapy with no success, and endocrine disorders have been ruled out.

5) Psychiatric Services --

a) Treatment -- when the services are provided by a physician who has been enrolled as an approved provider with the Illinois Department of Mental Health and Developmental Disabilities (DMHDD). Each recipient treatment program is subject to DMHDD limitations and must be approved by DMHDD before the services are provided.

b) Consultation -- only when necessary to determine the need for psychiatric care. Services provided subsequent to the initial consultation must comply with the requirements for treatment.

6) Services provided to a recipient in his place of residence -- only when the recipient is physically unable to go to the physicians's office.

7) Services provided to recipients in group care facilities by a physician other than the attending physician -- only emergency services provided when the attending physician of record is not available or when the attending physician has made referral with the recipient's knowledge and permission.

8) For services provided to recipients in a group care facility by a physician who derives a direct or indirect profit from total or partial ownership (or from other types of financial investment for profit) in that facility -- only when occasioned by an emergency due to acute illness, unavailability of essential treatment facilities in the vicinity for short-term care pending transfer, or when there is no comparable facility in the area.

9) Maternity care -- pre-natal, delivery and 6 weeks routine post-natal care for mother and child shall be treated as a combined service package except when care and delivery are provided by different physicians.

REQUIREMENTS FOR PRESCRIPTIONS AND DISPENSING OF PHARMACY ITEMS

Prescriptions

A physician may prescribe any pharmacy item not otherwise excluded which, in the physician's professional judgment, is essential for the diagnosis or accepted treatment of a recipient's present symptoms. The Department shall require prior approval for the prescription of any items not excluded and not listed, or in excess of the quantities listed, in its Drug Manual.

The physician shall:

1) Use his own prescription form (or the official form required by law for the prescription of controlled substances); and

2) Enter on the form the following information at a minimum -

a) Recipient's name
b) Date
c) Name of pharmacy item prescribed
d) Form and strength or potency of drug (or size of non-drug item)
e) Quantity
f) Directions for use
g) Refill directions
h) Legible signature in ink, and
i) Drug Enforcement Administration (DEA Number or Social Security Number (for physicians who do not have a DEA Number),

The Physician shall not charge for writing a prescription and shall not write prescriptions for injectables which are given in the physician's office.

Items which shall not be prescribed include the following:

a) Anorectic drugs or combinations including such drugs;
b) Biologicals and drugs available without charge from the Illinois Department of Public Health or other agencies;
c) Any vaccine, drug, or serum which is provided primarily for preventive purposes; e.g. influenza vaccine;
d) Vitamin B12 or liver extract except for patients with macrocytic anemia, e.g. pernicious anemia, the diagnosis of which is established on the basis of hematological studies;
e) Injectable drugs, when equally effective oral preparations are available;
f) Items such as dental products, hair products, facial tissues, infant disposable diapers, sanitary pads, tampons, soap or other personal hygiene products, articles of clothing or cosmetics of any type, proprietary food supplements or substitutes, sugar or salt substitutes, or household products; and

g) Infant formula, except for infant requiring a non-milk base product because of an allergic reaction to the usual infant products.

Dispensed Items

A participating physician may dispense pharmacy items listed in the Drug Manual. The physician shall not charge for any samples dispensed or anesthesia agents administered for office surgical procedures. The Department shall pay for items dispensed in an emergency or when not readily available from a pharmacy at the rate of the cost to the physician for the item, plus 20% of the cost, when itemized. The Department will pay a maximum of $1.00 for unitemized items.

NOTICE OF MEETING

AGENDA

Joint Committee On Administrative Rules
1818 State of Illinois Building
160 North LaSalle
Tuesday, January 24, 1978
10:30 A.M.

A. Old Business
   1. Approval of last meeting's minutes
   2. Status of Secretary of State's Rules on Rules
   3. Scheduling of monthly meetings

B. New Business
   1. Applicability of IAPA on State Universities
   2. Consideration of Joint Committee Purchasing Rules
   3. Review of Proposed Rules

      a. Illinois Dangerous Drugs Commission
         -Proposed amendment to schedule IV(d).
         -Notice published in Illinois Register: 12-23-77
         -Expiration of notice period: 02-06-78

      b. Department of Public Health
         -Proposed amendment to the Illinois Water Well Pump Installation Code Rules and Regulations
         -Notice published in Illinois Register: 12-23-77
         -Expiration of notice period: 02-06-78

      c. Department of Public Health
         -Proposed amendment to the Illinois Water Well Construction Code Rules and Regulations
         -Notice published in Illinois Register: 12-30-77
         -Expiration of notice period: 02-13-78

      d. Department of Public Health
         -Proposed amendment to rules for the licensing of hospitals
         -Notice published in Illinois Register: 12-30-77
         -Expiration of notice period: 02-13-78

      e. Department of Public Health
         -Proposed amendment to the Illinois Food Service Sanitation Rules and Regulations
         -Notice published in Illinois Register: 12-30-77
         -Expiration of notice period: 02-13-78

ALAN J. DIXON
Secretary of State

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